



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Downtown Performance Medical

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-14-1554-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 31, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted the medical bills related to the services rendered on 3/6/13 on 3/15/13 then again on 6/6/13 and 9/10/13 with no response."

Amount in Dispute: \$475.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is reviewing for proper payment."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 6, 2013	Physician Services	\$475.33	\$50.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out procedures for medical payments and denials
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. No explanation of benefits available from either party.

Issues

1. Did the respondent process the disputed services within Division guidelines?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?

Findings

1. The respondent stated in their response, "The carrier is reviewing for proper payment." 28 Texas Administrative

Code §133.240 (a) states in pertinent part, “(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.” No evidence to support such payment or denial was submitted with this response. The carrier's position is not supported. Therefore; the disputed charges will be processed according to applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c) states, “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service annual conversion factor)”. The fee calculations are as follows;
 - Per Medicare policy, procedure code 97010, service date March 6, 2013, is a bundled code. No separate payment is made.
 - Procedure code G0283, service date March 6, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.18162. The practice expense (PE) RVU of 0.21 multiplied by the PE GPCI of 1.002 is 0.21042. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.40127 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$22.19. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at \$22.19.
 - Per Medicare CCI Guidelines, procedure code 97140, service date March 6, 2013, may not be reported with procedure code 97150 billed on this same claim.
 - Procedure code 97150, service date March 6, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.29 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.29261. The practice expense (PE) RVU of 0.21 multiplied by the PE GPCI of 1.002 is 0.21042. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.51226 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$28.33. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The first unit is paid at \$28.33.
 - Per Medicare CCI guidelines, procedure code 97110, service date March 6, 2013, may not be reported with procedure code 97150 billed on this same claim.
3. The total allowable reimbursement for the services in dispute is \$50.52. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$50.52. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$50.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$50.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 1, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.